REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for Health** **2. The Care Quality Commission**
1	**CORONER** Christopher Peter Dorries, senior coroner for the South Yorkshire (West) area.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. (1) Where – (a) A senior coroner has been conducting an investigation under this Part into a person's death (b) Anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and (c) In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner
3	**INVESTIGATION and INQUEST** On 10th July 2013 I commenced an investigation into the death of Miss Lucy Moffatt (aged 31). The investigation concluded at the end of the inquest on 8th May 2014. The conclusion of the inquest was that Miss Moffatt died of injuries sustained in a fall from the second floor window of her room at a Crisis House in Sheffield. The jury returned a narrative conclusion to the effect that: (1) Miss Moffatt was suffering an acute phase of a mental illness at the time of her fall (paranoid delusions). The uncontradicted evidence was that she likely believed she was escaping from imprisonment where she would be raped and murdered. (2) The jury could not determine whether Miss Moffatt had exited the window having

	found the restrictor to be unlocked or whether she had defeated the lock with an implement, those being the only two possibilities on the evidence. (3) The jury found that system in place at the time was deficient in that it was not robust, competent or sufficiently monitored to prevent residents opening a window beyond 100mm.
4	**CIRCUMSTANCES OF THE DEATH** On the 9th July 2013 Miss Moffatt was admitted to a Crisis House in Sheffield because of a recurrence of her paranoid schizophrenia. Some hours later she fell or jumped from the second floor window of her room whilst in an acute paranoid state. Psychiatric evidence was that Miss Moffatt was likely under a belief that she was being imprisoned and would be attacked then killed. It was said that Miss Moffatt could probably not judge how far her window was from the ground during her 'escape'. The large opening frame of the window to the room was meant to be secured by a window restrictor of the common type where a cable mounted to the opening frame clips into a socket mounted to a non-opening part of the frame. This would restrict the opening to 100mm. In fact, the evidence clearly demonstrated that: (1) if the cable was merely clipped in to the socket by a simple push it would appear secure when pulled or tugged. However, just by pushing the key-lock/release button of the socket the cable was released. The cable was only secured when the release button was physically locked with a key. (2) even if locked with a key, the lock was easily defeated within (literally) no more than a couple of seconds by inserting the blade of scissors into the lock and turning it as if using a key. This was demonstrated to the jury (on an identical socket, using scissors from the court) by a member of staff from the Crisis House who had made this discovery shortly after the death. Staff at the Crisis House were unaware of either of the above points at the time Miss Moffat was given access to her room. It was said that the security of the window lock had been checked by 'pulling and tugging' the cable but not by pushing the release button or noting the keyhole position. It should be noted that there was no suggestion at the inquest that the particular window restraint in use at the Crisis House was any different to others of the same basic type from different manufacturers. Although there is no suggestion that Miss Moffatt obtained a key, the keys for the window restraints (the same key fitting all locks) were held in a securable cabinet within the Crisis House office but there was no apparent system for registering keys in or out, or otherwise knowing who had keys etc. In fact, after the death, a key was found in the lock of a window restrictor in a (ground floor) toilet adjacent to the office with no means of knowing how it had got there. It is also of note that the Crisis House was newly opened and had undergone a pre-registration inspection by the CQC in the Spring. The Inspector gave evidence that she checked appropriately for the presence of window restraints at the time, describing the model used as a common one that she knew could appear locked but would open on the push of the button. She understood that the residents were to be of low risk and expected the mechanism to be locked. She did not inform any of the staff accompanying her on the inspection that the restraint could appear locked when it wasn't. Finally, the Dept of Health had issued an Alert concerning the strength of window restraints six months before the death, referring health care organisations to Health Technical Memorandum (HTM) 55. Properly secured, the window restraint in question was of sufficient strength although it was apparently 'capable of being disengaged without the use of a special tool or key'. However, neither the pre-registration CQC

	Inspector nor a CQC Inspector who made an unannounced visited to the Crisis House after the death were aware of the Alert.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) That the type of window restraint in question can appear secure to a 'pulling and tugging' check when it is not actually locked. This can mislead those unaware of the issue. (2) The lock on the window restraint could easily be defeated with a pair of scissors and this may be the case on many similar devices. (3) Although the provider in question has now taken appropriate action, it may well be that many other such establishments have no proper system of window restraint key restriction. (4) The CQC Inspectors had not apparently been made properly aware of the Dept of Health Alert on a matter that they were expected to check. (5) There is no system to ensure that CQC knowledge of a potentially misleading situation with the window restraint lock was passed on, albeit in the belief that the restraint would be locked and that residents would be low risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th August 2014. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • the family of Miss Moffatt • Rethink Mental Illness (—note that I am satisfied from evidence given that Rethink have already taken appropriate action and they are not therefore being sent a copy of this report for formal reply. • Sheffield Health and Social Care Trust (• Sheffield City Council ( ) I have also sent it to the following who may find it useful or of interest: • Health and Safety Executive) • Patients Association

	• [redacted] I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**10th June 2014** ***Christopher P. Dorries***